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Concerning Depression and Suicidal Behavior in Children and Youth – Selected Aspects and Research

Wokół depresji i zachowań suicydalnych dzieci i młodzieży – wybrane aspekty i badania

Keywords:
depression,
suicidal behaviors,
suicides,
children, youth

Summary: The article presents the problem of depression and suicidal behavior among children and youth. On the basis of the review of many research studies and statistical data, it is observed that this problem is escalating. Among other things, the text also underlines the conditions, the range, and the symptoms of depressive behavior, with an emphasis on the most destructive effects of depression – suicidal behavior and suicide in children and youth.

Słowa kluczowe:
depresja,
zachowania
suicydalne,
samobójstwa,
dzieci, młodzież

Streszczenie: W artykule przedstawiono problem depresji i zachowań suicydalnych dzieci i młodzieży. Na podstawie przeglądu wielu badań i statystyk zauważa się, że problem ten eskaluje. W tekście zwrócono uwagę m.in. na uwarunkowania, skalę i symptomy zaburzeń depresyjnych, wskazując na najbardziej destrukcyjne skutki depresji, jakimi są zachowania suicydalne (samobójstwa) podejmowane przez małoletnich. Tekst kończy podsumowanie i wnioski zawierające propozycje zmian i udoskonaleń w profilaktyce.

Introduction

The problem of depression, directly linked to the high risk of suicide attempts by children and youth, is becoming more and more visible in Western society. Numerous studies indicate that today, in fact, we are dealing with it all over the world. According to the World Health Organization (WHO), depression is developing at an extremely fast pace. It is even estimated that by 2020 it will have become the second most common cause of human disability in the world. One of the European countries with the highest number of people with anxiety disorders and depression is Spain. According to studies conducted in the country, in the general population of children, the rates of depressive disorders (including anxiety disorders) are as follows: 0.5% for children under 6 years of age; 2.5% for children from 6 to 12 years old; 6.5% for young people (Sánchez-Hernández, Méndez & Garber, 2015, pp. 63–76). It might seem that these indicators are not very high, but, bearing in mind the effects of depression and the role it plays in the behavior of a young person, they are very worrying, as depression is one of the main risk factors for attempting suicide.

Suicide is a serious problem for young people. It is currently the third most frequent cause of death, accounting for 10% of all deaths of people aged 15–19 (Wasserman, Cheng & Jiang, 2005, pp. 114–120). The suicide rate increases tenfold from preadolescence to early adulthood. According to the Japanese Vital Statistics Report, the highest number of deaths between 15–39 years of age is due to suicide. The rate of suicide committed by Japanese teenagers corresponds to the number of teenage suicides in the world. In 1990, this number was four per 100,000 population, and by 2010, it doubled (Kawabe, Horiuchi, Ochi, Oka & Ueno, 2016, p. 231). Adolescent suicides are becoming a serious public health problem, the consequences of which are felt by all of us.

This paper is of a theoretical and review nature and concerns the problem of depression and suicides undertaken by children and adolescents. Based on a thorough review of the literature on the subject, the most important determinants (risk factors) and symptoms of depression in minors are approximated, indicating its most serious effects – suicide attempts and suicides.

From Depression to Suicidal Behavior[1] and Suicide[2] – Selected Conditions, Symptoms, and Research

Depression belongs to the group of affective disorders (i.e., mood disorders). Depending on the severity of the symptoms, a mild, moderate or severe depressive episode is diagnosed. Depressive disorders also occur in people who have not been diagnosed with an affective disorder, but, for example, with mixed anxiety-depressive disorders or adaptive disorders (depressive reaction). In the group of people with these disorders, the manifestation of depressive symptoms is associated with current difficult experiences. For children, this is very often school-related stress (excessive pressure and demands, increased competition among students, violence at school, etc.) (Turno, 2010, p. 7).

Researchers indicate that one of the most important causes of the depressive disorder may be the separation of a child from parents (or a parent) resulting from, for instance, labor migration.[3] From the cohort studies carried out by M. Abas, K. Tangchonlatip, S. Punpuing, T. Jirapramukpitak, N. Darawuttimaprakorn, M. Prince and C. Flach (2013, pp. 226–234), it appears that the children of migrant parents experience an increased risk of depression. Researchers say that the appearance of depressive disorders in children (adolescents) of migrant parents is also influenced by other factors directly related to the family, e.g., alcohol-related problems or violence. Integration and intensification of these factors may contribute to depression in children, which, according to psychoanalytic analyses, goes back to early childhood experiences. In addition, depressive disorders do not disappear, but are a developmental stage associated with the identification and externalization of the so-called "good object." For children, this object may be a parent (mother or father); their

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[1] The term "suicidal behavior" covers a wide range of behaviors (from suicide attempts, passive and active suicide threats, to suicides) manifested in various forms (suicide pacts, extended suicides, instrumental suicides, parasiticides, imitation suicides, and others). There are many different suicide classifications in the literature on the subject, taking into account the effect and/or purpose, conditions, the number of people involved in the suicide act, and the participation of third parties (Sobkowiak, 2011, p. 38).

[2] According to Émile Durkheim (2006, p. 51), suicide is every case of death resulting from a victim who knew that it would produce such a result. A suicide attempt is a previously determined action, with the difference that it does not lead to death.

[3] In addition to depressive disorder, children of migrant parents (for gainful employment) experience many emotional disorders, such as feelings of regret, injury, rejection, loneliness, depression, sadness, crying, anxiety, fear, guilt, etc. (for: Winiarczyk, 2011, pp. 71–80).

loss or "disappearance" may cause depressive disorders (Rancew-Sikora, 2012, p. 82). Reviewing a variety of different studies, J. Bomba (2009, pp. 35–42) indicates that the mechanisms of depression in children and adolescents are formed as a result of stressful life experiences, genetically conditioned susceptibility to mood disorders, poor adaptation mechanisms under stress (e.g., escape, avoidance) and inadequately negative cognitive interpretations.

The etiological dimension of depression in children and adolescents includes the concurrence of many, often complex, biological, psychological, social and environmental factors. Therefore, researchers have specified the so-called integrated biopsychosocial model, within which one can distinguish the functions that predispose, release and sustain the variety of factors that are interacting with each other (Kołodziejek, 2008, p. 17). In the group of predisposing factors, those of a personal and environmental nature are distinguished (social context at the early stage of the child's life). The personal factors include:

- "genetic susceptibility, occurrence of mood disorders in the family, early childhood disease, depression biological reactions to stressors (eating disorders, sleep, fatigue)" (Kołodziejek, 2008, p. 17);
- "psychological characteristics associated with intellectual development, individual vulnerability to hurt, external locus of control, cognitive depressogenic information processing, poor emotional regulation, low social skills also in the field of problem solving" (Kołodziejek, 2008, p. 17).

The group of environmental factors, on the other hand, includes:

- an uncertain or disturbed type of emotional bond with parents, which is shaped, among others, as a result of the lack of availability of the parents for the child, including insufficient sensitivity to the child's behavior and situations in which the child is ignored. This state of affairs, often in adolescents, results in a higher level of depression, distorted self-image,[4] and the inability to regulate affective states. Research shows

[4] According to Rogers' theory, self-image is shaped by human interaction with the environment. The quality of experiences related to oneself in contact with others builds a positive or negative attitude towards oneself. The most important in this respect are relations with significant persons during childhood. In the case of children, they are parents/guardians with whom they stay on a daily basis. Parents accept certain behaviors of children, build a (positive) image of their self-esteem. All elements that are unfavorable or distorting as a result of satisfying the needs and acceptance of the child are removed or minimized. More on this subject: Hreciński & Uchnast, 2012, pp. 95–115.

that adolescents with parental attachment anxiety are more vulnerable to depressive disorders (Kołodziejek, 2008, p. 17).

- problems in relationships with parents (Goodman & Gotlib, 1999, pp. 458–490): inappropriate, mainly negative parental attitudes[5] (cold, rejecting, distanced), restrictive educational methods, and lack of help and support from the parents (Przybysz-Zaremba, 2014, pp. 144–148). According to the research, weak "parental practices," including above all inappropriate educational methods (mainly severe discipline and inappropriate parental attitudes), are responsible for about 30–40% of aberrant (disturbed) behavior (Reinke, Splett, Robeson & Offutt, 2009, pp. 33–43) in the very early stages of a child's life.
- disorganization of family life and unavailability of parents due to their illness (e.g., depression or severe somatic illness). Research (Cummings & Davies, 1994, pp. 73–112; Ramchandani, Stein, O'Connor, Heron, Murray & Evand, 2008, pp. 390–398) indicates that mother's depression and father's helplessness (the father is unable to cope with his duties which the mother has been doing so far) can cause harmful and long-lasting cognitive and socio-emotional effects in the child's development, which later become manifest, e.g., in social maladjustment, depressive disorders and suicide attempts. Studies conducted by L. Loon, M. Ven, K. Doesum, C. Witteman and C. Hosman (2014, pp. 1201–1214) also indicate that children of parents with mental illnesses are often at high risk of developing the same mental illness. Interactions between parents with mental illness and their child/children are significantly worse compared to parents without a mental illness. The ill much less often monitor their children, which translates into a larger number of their problem/risk behaviors that adversely affect their health. Children of ill parents cannot count on their support – they are doomed to "being adult." Research carried out in the United States by R.C. Meldrum, G.M. Connolly, J. Flexon and R.T. Guerette (2015) indicates that the lack of proper control of parents shapes low self-control in minors, which may lead to them engaging in various criminal, as well as suicidal, behaviors.
- alcohol abuse and/or drug use by caregivers, which often constitutes a source of aggression/violence in the family. It is estimated that there are

[5] See: Plopa, 2005; Ziemska, 2009; Braun-Gałkowska, 1985.

around 6 million people abusing alcohol in Poland, and 2.5 million consume it in a way that is harmful to their health. The number of drug addicts is estimated at around 12,000 (Tkocz-Piszczek, Wolny, Kempa, Piszczek & Olcha, 2013, p. 8). Unfortunately, it is noticed more and more often that, for a better euphoric effect, drugs are washed down with alcohol and vice versa – drugs are used under the influence of alcohol. The integration of these two factors carries dangerous consequences for the whole family system and for children and adolescents in particular. In the United States, family violence annually affects more than 10 million households; 35% of the perpetrators of parental violence consumed alcohol or drugs before an incident related to violence (Assis, Oliveira, Pires, Avanci & Pesce, 2013, pp. 36–48). The presence of these factors in the family may translate into suicidal behavior on the part of minors.

- low social status of the family and poor social and living conditions can be an important determinant of the development of depressive disorders in children and adolescents. It should be noted, however, that these factors do not in and of themselves lead to depression of minors, but their integration with other environmental factors (family, social, school) may contribute to the formation of depressive disorders. An important role in this situation is also played by the personal (genetic) factors of the individuals referred to above. From the research carried out among 20,000 Danish youth who attempted suicide, it follows that the risk of attempting suicide by people living in the worst socio-economic conditions is more than five times higher (Qin, Agerbo & Mortenson, 2003, pp. 765–772) than by people living in good and very good conditions.

The group of triggering factors includes various unfavorable situations and critical events in the lives of children and adolescents. This may comprise, for example, difficulties in contact with parents (parents use impaired or no control), peers and teachers, school failures, lack of support in an educational institution, illness, use of psychoactive substances or their abuse, the use of violence, changes in the environment of residence, etc. (Kołodziejek, 2008, p. 18). In turn, the group of the so-called supporting elements are all the above-mentioned biological, cognitive, emotional, interpersonal and social components, which may be both susceptibility and risk factors for depression, as well as significant factors supporting the disorder, i.e., intensifying and preserving symptoms reinforcing the interacting factors (Kołodziejek, 2008, p. 18).

Depression in childhood and adolescence is rare in its pure form. It is often accompanied by anxiety disorders (30–75% of children with depression meet the criteria for anxiety disorders), externalizing disorders such as: behavioral disorders (CD), oppositional defiant disorder (ODD), attention deficit hyperactivity disorder (ADHD) and disorders associated with the use of psychoactive substances. Researchers indicate that girls with depressive disorders more often associate with anxiety disorders, while boys with depression tend to associate with behavioral disorders and ADHD. Differences are also observed in older and younger children. For example, in younger children manifesting depressive disorders, suicidal ideation, which may translate into suicide attempts, is less frequent (Turno, 2010, p. 9). The characteristic symptoms of depression which are visible to the naked eye include "sadness, limitation or abandonment of interests and activities that one has so far enjoyed, changes in the scope of psychomotor activity – slowing or stimulating, a sense of hopelessness, a feeling of meaninglessness, low self-esteem, an excessive sense of guilt, a sense of helplessness, recurrent thoughts of death or suicide, a drop in energy, excessive fatigability, attention deficit, increase or decrease in appetite and changes in sleep pattern (persistent difficulty falling asleep or early awakening, e.g., around four and five in the morning)" (Turno, 2010, p. 9). In the case of youth (Kępiński, 1973), feelings of helplessness, hopelessness (lack of hope) and guilt are more often observed. In addition, there may be panic attacks, obsessive-compulsive disorder, eating disorders, oppositional defiant disorder, activity disorders and attention disorders. The diagnosis of depression in adolescents should also take into account the coexistence of somatic diseases (e.g., mononucleosis, latent hypothyroidism, nutritional deficiencies, anemia, chronic pain syndromes of various etiology, etc.) (Klimaszewska et al., 2007, pp. 408–416). Statistics show that depressive disorders affect about 20% of adolescents under the age of 18 (Kołodziejski, 2015, p. 36). They may persist for a relatively long time, even despite treatment (Klimaszewska et al., 2007, pp. 408–416).

As confirmed by research, depressive disorders can manifest very tragically among children and adolescents, i.e., through suicide attempts and suicides committed. According to the World Health Organization (WHO), in the last 45 years, the total number of all suicides in the world has increased by 60%. Suicide is one of the three leading causes of death in the population aged 15–44. It is estimated that attempts to commit suicide occur 20 times more often than suicides ending with death. The number of suicides committed by young

people is increasing. About 90% of suicides are associated with depression (Szymańska, 2012, p. 12) and the use of various substances, such as alcohol, drugs and other psychotropic substances (Gromulska, 2010, pp. 127–132). In the report entitled "Preventing Suicide. A Global Imperative," WHO indicates that someone in the world commits suicide every 40 seconds. Among youths aged 15–29, suicide has become the second leading cause of death (WHO, 2014).

According to the WHO report, the suicide problem affects all countries. In each of them, the indicator is at a different level. In 2009, the largest number of suicides per 100,000 people in Europe was noted in Lithuania (34.1), Russia (30.1), Belarus (28.4), Hungary (24.6), Slovenia (21.9) and Ukraine (21.2). In Poland, the suicide rate is 16.9 (WHO, 2014).[6] In turn, Mexican studies conducted among children and adolescents in the period 1998–2011 show an increased rate of committed suicides (from 18.5 to 31.9 per 100,000) (Sánchez-Cervantes et al., 2015, pp. 379–389).

According to researchers, the most common causes of juvenile suicides are mental disorders (including depression), unfavorable family situation of the individual and social environment impacts constituting a group of integrated risk factors (Sánchez-Cervantes et al., 2015, pp. 379–389; Gary, 2005, pp. 170–211).

The problem of suicide in children and youth also applies to Poland. On the basis of the data of the Central Statistical Office, E. Napieralska (2010, p. 92) discusses in detail the characteristics of suicides of children and adolescents from 1999 to 2006. During this period, 2556 young people died of suicide. The vast majority were boys: 2181 cases, which in the age group 10–14 constituted 79.38%, while in the age group 15–19 age group, 86.09%. The author notes a proportional increase in the number of suicides and a larger percentage in subsequent years of life.

In turn, according to studies conducted by I. Pospiszyl (2009), the most suicides are committed by young people aged 15–24, and suicide attempts are more often carried out by girls than boys. In the years 2004–2014, the number of young people attempting suicide has increased. A detailed list of the data according to age is presented in Table 1.

[6] These figures include everyone (adults, children, adolescents) who has attempted suicide or committed suicide.

Table 1
Age and number of people attempting suicide

Year	Up to 9 years	10–14 years	15–19 years	20–24 years
2004	2	53	372	546
2006	2	48	345	489
2008	1	53	362	476
2010	0	42	153	292
2012	0	30	343	525
2014	2	71	526	1015

Source: Wasilewska-Ostrowska, 2015, p. 154.

Analyzing the etiology of the elements leading to suicide attempts or the committing of suicide, it should be pointed out that this is a complex process consisting of several elements (i.e., suicidal thoughts, suicide attempts and suicide), which is often influenced by a number of closely integrated factors. According to B. Hołyst (2012, pp. 19–42), suicidal behavior is influenced by various reactions released in a person when suicide appears in his/her consciousness as an anticipated or desired state of affairs, and thus as a goal. Suicidal behaviors may have the form of imagined, desired, attempted and accomplished suicides. They are shaped as a result of the interaction of socio-cultural, developmental, psychological, family and environmental factors. Due to the fact that suicidal behaviors have similar conditions to the depressive disorders which were analyzed in more detail above, only the general scheme of factors contributing to the occurrence of suicidal behavior is presented below.

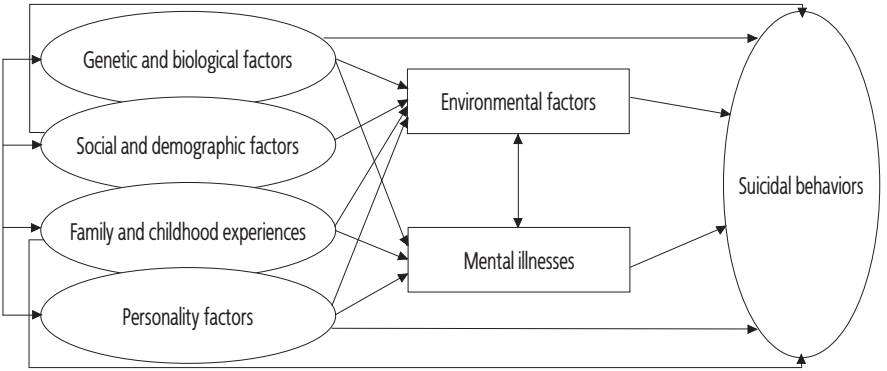

Figure 1.
Factors related to suicidal (suicide) behavior of children and adolescents.
Source: Prusik, 2015, p. 99.

It is worth stressing, however, that many studies (Załęski, 1992; Rosa, 1996; Hołyst, 2012; Szymańska, 2012; Carr, 2004, pp. 54–59; Dubois & Miley, 1996, p. 125; Braiden, McCann, Barry & Lindsay, 2009, pp. 81–93) regarding the conditions of suicidal behavior in minors indicate that the reasons for suicide attempts most often relate to the family. These include a wrong (bad) atmosphere at home, alcohol problems in the family (most often the father), conflict with father, failure in learning, conflict with siblings, abandonment by a boyfriend (girlfriend), conflict with mother, rejection by peers and loss of a loved one (e.g., death of the mother or father). Also, there are groups of risk factors for committing suicide in other areas of adolescent life (e.g., at school – poor relations with the teacher, negative atmosphere, etc., or in a peer group).

Suicide rarely happens suddenly. It is the result of a longer process during which there is an imbalance between risk factors and protective factors. The longer the risk factors predominate, the greater the risk of suicidal behavior in minors. An adolescent who finds himself/herself in a difficult situation experiences strong emotions that are revealed in fear, anger, regret, shame, humiliation and feelings of guilt and sadness, which, after some time, lead to a state of permanent emotional overload and depression. In the absence of support and help, young people consider their situation to be hopeless and search for a way out of it, for an "escape." The activities they undertake are divided into three stages: suicidal thoughts, suicidal intentions (suicidal tendencies) and committed suicide (Szymańska, 2012, p. 15). According to the American

Association of Suicidology, 80% of people who intend to commit suicide make an attempt to inform their immediate surroundings about it in various ways (i.e., by sending various verbal and non-verbal signals) (following: Szymańska, 2012, p. 16). Unfortunately, the public is not always able to read these signals. According to the works of Alan Apter and Danuta Wasserman (2003), 25% of teenagers examined after an unsuccessful suicide attempt sought help in adults but did not receive it. The signals that minors send to the environment (adults, parents, teachers) can be divided into two groups: early warning signals and high-risk signals. They are presented in Table 2.

Table 2
Selected symptoms (signals) of suicidal behavior (suicides) of adolescents

Early warning signs	High threat signals
Withdrawing from contacts with family and friends, turning away from them. Interest or even preoccupation with the theme of death. Clear personality changes and serious mood changes. Difficulties with concentration. Difficulties at school, a drop in the quality of work and grades. Change of current habits regarding food and sleep (loss of appetite or overeating, insomnia or excessive sleepiness). Loss of interest in entertainment. Frequent complaints about physical ailments, usually associated with emotions, such as headaches, stomach pains or fatigue. Constant boredom. Loss of interest in things and matters that the young person had previously cared for (e.g., refusal to take care of oneself).	Talking about suicide or planning it. Increased impulsiveness: sudden impulsive actions, such as acts of aggression and violence, rebellious or escape behaviors (resulting from enormous emotional tension). Sudden alcohol or drug excesses (an attempt to anesthetize suffering or a form of calling for help). Rejection of help, feeling that it is impossible for anybody to provide help. Accusation: "I am a person" or a sense of "corruption (rotting)" inside. Messages about the hopelessness of life, no exit, own worthlessness. Rejection of received praise or prizes. Throwing messages such as: "Soon I will stop being a problem for you," "It does not matter," "It doesn't matter anymore," or "We will not see each other anymore." A sudden transition from depression to the state of contentment (after a period of internal struggle, the person has already decided to escape from problems and end his/her life). Distributing favorite items among friends, giving away pets. Preparing a will. Using phrases emphasizing low self-esteem: "I am nothing," "Do not take care of me," "I would like to die," "I'm going to kill myself," "I should not have been born."

Source: Szymańska, 2012, pp. 15–16.

Each suicide is entangled in the unique world of the individual (Pilecka, 1995, p. 9). It is an individual act. Thus, the symptoms and signals revealed are individual behaviors of a person, requiring a unique approach and the design of preventive actions taking into account these individual behaviors.

Summary and Conclusions for Practice

From the studies and statistics quoted above, it appears that depression and suicidal behaviors (suicides) are an important and complex problem escalating in contemporary society. This requires many further studies and analyses regarding the etiology, determinants and dynamics of depression and suicidal behavior, and, above all, the implementation of effective prophylaxes. The complexity of the determinants of depression and suicide attempts undertaken by children and adolescents indicates that currently undertaken preventive measures[7] do not bring the expected results – the problem continues to grow. Specialists suggest that an "ecological prevention model may be effective, taking into account both the elimination or reduction of all modifiable risk factors (individual, family, school, environmental), as well as the strengthening of protective factors" (Szymańska, 2012, pp. 19–20). Preventive actions should be long-term and should be implemented at all levels of prevention. They ought to include both children and adolescents (students), as well as the people involved in their upbringing, i.e., parents, teachers, educators, etc. Prevention should be implemented already in the first institutions of the care and education of children, i.e., nurseries and kindergartens, and then fixed at school. It should be based on a reliable diagnosis of risk factors in various areas of the functioning of children and adolescents, which then become the basis for the design of preventive actions. These activities require proper preparation of primarily the educational and pedagogical staff whose knowledge, competences and skills are aimed at implementing information and education strategies among students, their parents and the local environment. In the case of prophylactic interactions addressed to children and adolescents, an important element is their active inclusion in the design and implementation of programs, taking into account their potential (interests, predispositions and competences), which is often underestimated and even "wasted."

[7] The statement that preventive actions do not produce the desired effects was made on the basis of the referenced studies and statistics.

Contemporary prevention of depression and suicidal behavior should aim to build heterogeneous and integrated activities that take into account the three main living environments of children and young people: family, school and local community. It should teach them how to function properly in these areas and, above all, equip them with skills to deal with the difficulties and problems encountered and seek help.

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